2007 Health Insurance Application Instructions -- PAGE 1
KENTUCKY TEACHERS' RETIREMENT SYSTEM

Reason for Application

- **New Retiree:** Check this box if you are a new retiree of the Kentucky Teachers' Retirement System.
- **Open Enrollment:** Check this box if you are filling out this application due to Open Enrollment.
- **QE:** Check this box if you are making a change to your coverage Option, as permitted by a valid QE.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator and must provide supporting documentation, as required.
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide a date and an explanation if "Other" is selected.

NOTE TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.

- Enter the effective date of coverage.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- If you are not the retiree and you are applying for health insurance coverage, enter your relationship to the retiree (SP = Spouse or CH = Child).
- **RETIREE**: If you are the retiree, enter your Social Security Number and your name (First, MI, Last) and go to *Applicant Specific Information* below.
- **APPLICANT**: If you are not the retiree:
    - Enter the retiree's Social Security Number and the retiree's name (First, MI, Last) in the space labeled *Retiree* above.
    - Enter your Social Security Number and your name (First, MI, Last) under *Applicant*.
    - Go to *Applicant Specific Information*.
- **APPLICANT Specific Information**:
    - Enter the Planholder's Address (including County of Residence), Date of Birth, Home and Work Phone Number, email address if available, Smoking Status, Gender and Marital Status in this section.

Note: If the smoking status flag is not checked, this application will be pended until the information is provided. The smoking status that you select during Open Enrollment or as a new retiree will remain for the entire Plan Year. A change in your smoking status is NOT a qualifying event.

2007 Health Insurance Application Instructions -- PAGE 1 Continued…
KENTUCKY TEACHERS' RETIREMENT SYSTEM

SECTION II: PLAN ELECTION – *If waiving health insurance coverage, go to Section V.*

1. **Option:** Mark the box that indicates the option you are electing. For a description of each option, see the Health Insurance Handbook. **Elect only one**.
2. **Level of Coverage:** Mark the box that indicates the level of coverage you are electing. For a description of each level of coverage, see the Health Insurance Handbook. **Elect only one**.
3. **Cross-reference:** If you wish to pay by cross-reference, mark this box and complete sections III, IV and VIII. If you wish to pay by cross-reference, **ONLY ONE** application is required. The person listed in *Section I: Demographic Information* will be the planholder of the cross-reference payment option.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse, dependent child(ren)** or have chosen the **cross-reference payment option** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another Health Insurance Application. Do not complete this section if you are electing Single coverage.

Relationship Code: Enter the appropriate relationship code as follows:

- **SP** Spouse (your eligible spouse).
- **CH** Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent and who is not disabled) age 0-23. (To enroll, a dependent must be age 23 or less and not turn 24 during the coverage year.)
- **DD** Disabled Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.
- **CO** Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance or an eligible dependent child of whom you have full guardianship).

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are electing to pay by cross-reference.

- Enter your spouse's company number. **Required.**
- Enter your spouse's dual employee indicator if applicable.
- Enter your spouse's smoking status. **Required.**
- Enter whether or not your spouse is a hazardous duty retiree.
- Enter your spouse's hire date or retirement date, if applicable. This field is needed if the planholder elects to start a cross-reference payment method when his/her spouse becomes employed or newly retired with an agency that participates in the Kentucky Employee's Health Plan.
- Enter your spouse's deduction start date. This field is only needed if the policyholder elects to start a cross-reference payment method with a Board of Education employee.

2007 Health Insurance Application Instructions -- PAGE 2
KENTUCKY TEACHERS' RETIREMENT SYSTEM

Enter the social security number of the retiree in the spaces provided on the top left hand corner of Page 2. Enter the social security number of the planholder (and applicant if applicable) in the spaces provided on the top right hand corner of Page 2.

SECTION V: WAIVING HEALTH INSURANCE COVERAGE
Check this box if you choose to waive health insurance coverage with your retirement system.

SECTION VI: NOT APPLICABLE
NOTE: If a retiree elects to pay by cross-reference with an active spouse and the active spouse is eligible and would like to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active spouse's Health Insurance Application.

SECTION VII: COORDINATION OF BENEFITS
Check "Yes" if you or any of your dependents listed on this application are covered under another health insurance plan. Otherwise, check "No".

SECTION VIII: AUTHORIZATION AND CERTIFICATION
Read the statements in this section carefully. After you have read and understood the statements, sign your name on the "Retiree Signature or Applicant Signature" line and enter today's date in the line provided.

If you are applying to pay by **cross-reference**, your **spouse MUST also sign** the application on the "Spouse Signature" line. He/she **must also enter today's date** in the line provided.

Your cross-referenced spouse must have his/her insurance coordinator sign this form before you return it to your insurance coordinator.

Your **cross-reference application** will not be processed without the **four required signatures and dates**: planholder, spouse, planholder's insurance coordinator and spouse's insurance coordinator.

GENERAL REMINDERS:
Do not hold your application until the end of open enrollment. Return your application to your retirement system as soon as possible.

If you are planning to pay by cross-reference, it is very important that you start the application process as early as possible. Again, your cross-reference application requires only one application with four different signatures.

Additional copies of the completed application may need to be made if paying by cross-reference to ensure that all parties maintain a copy for their records.

Do Not Staple!

KENTUCKY EMPLOYEES HEALTH PLAN

HEALTH INSURANCE APPLICATION FOR THE KENTUCKY TEACHERS' RETIREMENT SYSTEM (KTRS)

PY 2007

Mail application to:
479 Versailles Road
Frankfort, KY 40601

INSURANCE COORDINATOR SECTION
__ __ / __ __ / __ __ __ __
Coverage Effective Date

8 5 0 0 0
Company Number

Reason for Application:

☐ < New Retiree ☐ < Open Enrollment ☐ < QE* ☐ < Previously Waived* ☐ < Other*

* If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____ (Date) AND a description of the Qualifying Event: _____ (Qualifying Event Description)

SECTION I: DEMOGRAPHIC INFORMATION

Is retiree applying for this coverage? ☐ < Yes ☐ < No

If "No", what is your relationship to the retiree? ☐☐

__ __ __ – __ __ – __ __ __ __
RETIREE SSN *(Required)*

_____
RETIREE Name (First, MI, Last)

__ __ __ – __ __ – __ __ __ __
APPLICANT SSN (If retiree is not applying)

_____
APPLICANT Name (First, MI, Last)

APPLICANT Specific Information

_____
Mailing Address

__ __ / __ __ / __ __ __ __
Date of Birth (MM/DD/YYYY)

_____ _____ _____
City, State, Zip Code | County of Residence | Country / Mail Code, if not USA

_____ _____ _____
Planholder's HOME Phone Number | Planholder's Cell Phone Number | Planholder's Email Address

Smoking Status *(Required)* *Note: Smoking status cannot be changed mid-year.*
Have you smoked in the last 2 months? ☐ < Yes ☐ < No

Gender
☐ < Male
☐ < Female

Marital Status
☐ < Married
☐ < Single

SECTION II: PLAN ELECTION- if waiving health insurance coverage, go to Section V.

1. Option (Check only one)	2. Level of Coverage	3. Cross-Reference Payment Option (Available for Family Coverage Only)
☐ < Commonwealth Essential	☐ < Single	☐ < Yes
☐ < Commonwealth Enhanced	☐ < Parent Plus	**If Yes, you must complete Sections III, IV & VIII**
☐ < Commonwealth Premier	☐ < Couple	
	☐ < Family	

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you elected Single coverage, skip to Section VII*

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		

SECTION IV: CROSS-REFERENCE INFORMATION → *Complete ONLY if you checked Yes in Section II, box 3*

Your Spouse's Company Number: ***(Required)***	Dual Employee Indicator, If applicable	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouses Hire Date or Retirement Date:	Your spouse's Deduction Start Date (If BOE employee):
_____	☐ <Yes	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____	_____

PY **2007**

			–			–					

Retiree's SSN

			–			–					

Applicant's SSN (If other than retiree)

SECTION V: WAIVER

Do you wish to waive your health Insurance Coverage? ☐ < Yes

Reason for waiving _____

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account.

If a retiree elects the cross-reference payment option with an active spouse and the active spouse is eligible and wishes to enroll in the state's Flexible Spending Account Program, the active spouse and the retiree should make their health coverage elections by completing the active employee's Health Insurance Application.

SECTION VII: COORDINATION OF BENEFITS

Are you or any of your dependents listed on this application covered under another health insurance plan? ☐ < Yes ☐ < No

SECTION VIII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between myself, the Department for Employee Insurance and the TPA.
* **I understand that if my spouse and I elect the cross-reference payment option, our level of coverage (Family) cannot change if one of us terminates employment, and the remaining spouse will pay the full family contribution.**
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* I agree to abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
* I authorize the Retirement System to deduct from my retirement benefits the amount required to cover my share of the coverage I have selected.
* I authorize the Retirement System to release the information in this application to federal and state agencies for proper administration of medical benefits. Such release of information will be made only to the extent permissible under applicable state and federal statutes. I further acknowledge that Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* My signature below certifies that I have read the health insurance handbook and all materials provided to me and agree to be bound by all terms and conditions. All information listed on this application was completed with knowledge of the material's terms and conditions, and I accept full responsibility for any deficiency concerning my application due to a failure to conform to the material's terms and conditions.

_____ _____

Retiree Signature — Date

_____ _____

Applicant Signature (if other than retiree) — Date

_____ _____

Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** — Date

_____ _____

Retirement Insurance Coordinator Signature — Date

_____ _____

Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference payment option** — Date